

# BEDSIDE MEDICINE FOR BEDSIDE DOCTORS

An Open Forum for brief discussions of the workaday problems of the bedside doctor. Suggestions of subjects for discussions invited.

## CANCER OF THE RECTUM

WILLIAM H. KIGER, M. D. (1930 Wilshire Boulevard, Los Angeles).—I have been requested to discuss this subject, with special reference to symptoms and prognosis. The latter depends so much on how early the former is recognized, and the proper treatment instituted, that it varies in the same ratio.

One of the earliest and most common symptoms is bleeding, but this may also occur late; so it is always a good rule to see if a patient complains of blood in the stool, and to find out where it is coming from. Changes in the bowel function such as constipation, diarrhea, frequency, loss of weight, discomfort, feeling of fullness, heaviness, or pain, should always be fully investigated. This should be done, first, by digital examination, and, if this is negative, then a complete proctoscopic should be made.

The majority of cancers of the rectum occur in the ampulla, or about the rectosigmoid junction, and at these points cause but little, if any, filling defects unless far advance, and a negative barium enema should not be regarded as final if a digital and proctoscopic examination have not been made. The early symptoms of cancer of the rectum are often so mild that they are not considered of any importance by either the patient or his doctor. It is my belief that the majority, if not all, of the cancers of the rectum and sigmoid are due to degeneration of simple adenomas, which are seen rather frequently in this location. They arise above the sphincter muscle and belong to the columnar cell growths, resembling the histologic structure of the mucous membranes from which they grow; they are adenocarcinomatous and closely resemble the benign adenoma and often appear pedunculated in the early stages. They can only be distinguished clinically when the broad infiltrated base shows its malignancy; but later ulceration occurs and the inflammatory change takes place. These cancers vary according to the histologic structure which predominates, but the scirrhous, or hard cancer, is the one most frequently found in the rectum. Ulceration comes on late in this variety, and consequently the constitutional symptoms of toxemia and cachexia are late in appearing. It often reaches an advanced stage before the patient is aware of its existence. The mild character of the symptoms during the early stage of the disease causes the patient to dismiss it from his mind as some simple ailment. Among the first symptoms that attracts the patient's attention is a sense of fullness within the rectum, and a feeling that the bowel has not been entirely emptied after evacuation, and later a soreness and tight

feeling, accompanied by straining and bearing-down pain during evacuation. The nearer to the anus the disease is located, the more marked are these symptoms. If the anus itself happens to be involved, they will have severe pains and often partial incontinence quite early in the course of the disease. Another early symptom is a slight morning diarrhea, due to the irritation of the retained feces above the obstruction. Later all these symptoms become aggravated, and they have a discharge of bloody mucus and pus, both from the sloughing cancer, and from the ulceration above, which is due to the pressure of and the toxins absorbed from the retained and hardened feces that are lodged in the dilated portion above the obstruction. The discharge has a peculiar odor, and once recognized is seldom forgotten.

The blood picture is of little importance until the later stages, when one often gets a secondary anemia. Distention of abdomen does not occur unless the growth has advanced far enough to cause a partial or complete obstruction. Unless the growth is large and high, you are not able to palpate.

Prognosis.—Age is a decided factor in the prognosis. Under the age of thirty-five it is usually unfavorable because of the high malignancy of the growth. But there may be exceptions to this rule. The writer had one case in 1926, at which time he removed a malignant ulcer, which was a degenerated adenoma, in a girl of twenty-two, and there has been no recurrence to date. In patients of seventy, or older, the growth of the cancer is not nearly as rapid as in a younger person, neither are they good subjects for radical surgery, so the prognosis in this class of cases is rather unfavorable. Location of growth has to do with its early symptoms and early recognition and treatment, "as time is the essence of the contract," is a very important factor in the prognosis. The degree of malignancy is graded from one to four, and the higher grades are the ones most prone to metastasize and recur; hence, the outcome is less favorable than in the lower grades. The mental attitude of the patient is a deciding factor in the final outcome of your surgery. The low and depressed patient has a poorer prognosis than the cheerful one.

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DUDLEY SMITH, M. D. (450 Sutter Street, San Francisco).—Early recognition and early operation are the essential factors in cure. On the whole, these cases are discovered relatively late. Nearly a year elapses, on the average, after symptoms have begun before these cases reach the surgeon, although diagnosis of cancer of the rectum

and rectosigmoid is easily made in 100 per cent of the cases by digital, anoscopic, and proctoscopic examination.

The frequency of cancer in this region lays a great responsibility upon the physician to investigate carefully all cases presenting any symptoms referable to the intestine or rectum.

A physician cannot be held responsible for late diagnosis in patients who have failed to consult him until late in the course of the disease; but it is a sad indictment when months are allowed to pass after the patient has consulted the physician before a proper diagnosis is made.

That the physician may be on his guard, consideration should be given as to what are the early symptoms of cancer of the large bowel. Any change in bowel habit or sensation should cause the physician to suspect trouble. The rectum is a silent area, and a growth usually gives no symptoms for the first six months; but even during this time there may be slight irritation or change in the character or frequency of the bowel movements. This is especially true in the papilliferous type, for this type grows rapidly and causes the secretion of considerable mucus. During this early period there may be a little discomfort in the rectum or a little more frequent urge to defecation. These minor symptoms may be ignored by the patient, but if any of them are called to the attention of the physician, an adequate examination should be made. When the lesion is at the rectosigmoid junction, rapid increase in constipation is a not infrequent symptom, because the lumen of the gut at this point is small and the growth constricts early. Distention by gas and colicky pains are frequent complaints. If the abdominal wall is thin, peristaltic waves will probably be seen. When blood appears in the bowel movement, it should be an imperative command to the physician to immediately find where it comes from.

If hemorrhoids which are bleeding or might bleed have been found, the physician cannot be absolved from blame if he does not investigate higher up and make sure that there is no other lesion from which the blood is coming. *Physicians, students, nurses, and the public, should be taught that blood from the rectum means cancer until cancer is ruled out.*

Every patient consulting a physician for any type of rectal trouble should have the benefit of routine proctoscopic examination. If this were done, many cancers would be discovered early; many unsuspected polyps would be seen and a considerable number of these would be found to be changing into early malignancy.

There are several reasons why these cancers are not discovered earlier. Some of these reasons are:

1. Patients put off coming to the doctor for any rectal symptoms as long as they can because they have been told by others that an examination of the rectum is a very painful procedure. This impression upon the part of the laity arises from the unnecessary pain and discomfort so frequently

suffered by the patient in the examination and treatment of rectal conditions.

2. The general impression that blood from the rectum means hemorrhoids.

3. Very frequently patients resort to rectal suppositories, which are prescribed by a friend, by the druggist, or by a physician who has made no examination.

Personal communications from fifty-seven Fellows of the American Proctologic Society support the writer's contention that rectal suppositories, so glowingly recommended to the medical profession by their manufacturers, are of no value in the treatment of anal or rectal disease. The names of some well-advertised brands should be changed to painusols, paranoids, sillycones, foldurols, and fannycain.

4. Inadequate examination of the patient. In over 90 per cent of rectal cancer a simple digital examination will reveal the growth. This fact adds force to the dictum of a well-known professor of medicine, who said to his students: "Put your finger in the rectum or you may later find you have put your foot in it." Adequate examination includes the following, and should be done in the order named: inspection, digital, anoscopic, sigmoidoscopic up to ten inches, and barium enema if the lesion is not found within the range of the sigmoidoscope.

5. Barium enema and x-ray examination. Reliance upon a negative x-ray report is a very frequent cause of delay in diagnosis. Growths below the rectosigmoid junction are rarely discovered by x-ray, and never until far advanced and constriction has developed.

6. Stool examination. Many cases are treated for months for amebiasis or dysentery when cancer has not been ruled out by adequate examination.

Microscopic examination should be done in all cases to corroborate diagnosis and especially for the purpose of grading the malignancy of the growth, which has an important bearing upon the treatment to be instituted in the individual case. A small piece, about one-eighth inch in width, should be nipped out with a biopsy forceps and the wound immediately cauterized with the electrocautery. Done in this way, the taking of a specimen does not increase the danger of metastasis and effectually prevents error in diagnosis. If a negative report is received and the lesion appears malignant to the examiner, a second specimen should be taken, which will, in all probability, confirm the diagnosis.

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MONTAGUE WOOLF, M.D. (384 Post Street, San Francisco).—Unless the patient is unwilling to have an operation or constitutional disabilities exist to prevent one, the treatment of cancer of the rectum is always operative. This dictum applies to any stage of the disease unless the growth is physically irremovable. Cancer of the anal canal, which is an epithelioma and thus differs from the adenocarcinoma of the rectum and colon proper,

should, likewise be removed by excision, cauterization, or curettage: but, in addition, radium is of greatest accessory value in treating this type of cancer.

**Local Excision With or Without Radium.**—It has always been controversial as to whether a cancer of the rectum as distinct from cancer of the anal canal may be locally removed without risking a recurrence. It is obvious that this may be done for two reasons: First, a growth may commence in a small adenoma, sessile or pedicled, and a change may not yet have reached its base. Second, it is well known that the lymphatics in the wall of the rectum are few and small, which allows a considerable time to elapse before the adjacent glands are contaminated by malignant cells. One can, therefore, report many a cure by local removal. A polypoid adenoma which has degenerated into a malignancy with the base still soft may be removed by a snare or knife and the site of origin well cauterized by heat. Should a growth fortunately be within an inch in diameter and loosely arising from the wall of the rectum, it may be removed by excising the whole wall of the rectum with a margin at least as wide as the growth. I believe it is fair to offer this patient such an alternative to the highly mutilating total extirpation of the rectum. In addition, whenever a small growth is locally excised, radium or radium seeds should be applied around the excised area. A small area of adenocarcinoma can be influenced profoundly by radium, and in case, for reasons mentioned above, an early growth may not be removed by resection of the rectum, even radium alone may be effective in curing the disease. But it must be applied so that there is an effective cross-fire of its rays, which means that it must be inserted under direct vision and usually by some surgical exposure of the area to be irradiated. Radium is of no value in surgically inoperable cancer.

**Epithelioma of the Anus.**—Epithelioma of the anal canal is much more sensitive to the effect of radium than adenocarcinoma. It is likely that radium procures all the effect of removal of the intestine. The use of radium is of the greatest use when the size of the growth is known exactly and when carefully planned insertion of the radium to cover all of it in every direction has been definitely mapped out. The foregoing may appear to differ from the views of some operators, but no less an authority than Lockhart-Mummery<sup>1</sup> substantiates the validity of the proceedings.

**Large Operable Growths of the Rectum.**—Larger operable growths of the rectum need radical excision of the intestine. The rectum is five inches in length and the anal canal one inch and a half. The growths will occur anywhere in these five inches.

There are two operations which in my experience are of such a desirable and fundamental nature as to be worth while standardizing. It must be remembered that in its early history a difficult

operation will be performed by the expert, and the survival of such an operation will depend on the possibility of its being adopted by surgeons in general. This prospect depends on a widespread application and a simplicity of conception although the operation may not be easy. The two operations which fit such offices are the abdominoperineal operation in one stage and the perineal resection of the rectum following a preliminary colostomy.

**Abdominoperineal Operation in One Stage.**—This operation may be termed the ideal procedure for removal of a growth which cannot be reached with safe limits by the perineal.

**Perineal Resection.**—This operation is, to me, the one of choice in most operations for cancer of the rectum. As much as sixteen inches of bowel may be removed at times from below. To remove eight or ten inches by this method should always be possible; certainly, if one and a half inches of the sacrum be removed for greater access to the tumor.

**Inoperable Growths of the Rectum.**—A cancer of the rectum may be inoperable on account of dangers attendant on old age, systemic disease, local extension or metastatic invasion. Radium or x-rays, the latter even of high voltage, in no way influence for good the duration or ultimate result of widespread growths. Still, some alleviation can be obtained by a colostomy, which prevents the fecal stream contaminating the area and so reduces to a minimum the occurrence of obstruction, inflammation, including perforation and formation, of an intra-abdominal or pelvic abscess. Pain, too, is often mitigated by an artificial iliac anus, and the life of the patient is often prolonged by it. Morphine should not be withheld when the pain becomes severe, but it is not unwise occasionally, in conjunction with this drug, to use pitressin in order to maintain the tone of the bowel.

Occasionally, in spite of small metastases being found in the liver, the growth should be resected in order to protect the patient from the discharge of blood and mucus, hemorrhage, and the sometimes excruciating pain caused by the infiltration of pelvic nerves. This depends on the size of the growth and applies mainly to perineal removal.

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Where education has been entirely neglected or improperly managed, we see the worst passions ruling with uncontrolled and incessant sway. Good sense degenerates into craft, and anger rankles into malignity. Restraint, which is thought most salutary, comes too late, and the most judicious admonitions are urged in vain.—S. Parr.

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To make the most of dull hours; to make the best of dull people; to like a poor jest better than none; to wear the threadbare coat like a gentleman; to be outvoted with a smile; to hitch your wagon to the old horse if no star is handy—that is wholesome philosophy.—Bliss Perry.

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Leisure, like wealth, comes to him who has skill in planning; it is seldom put to good uses if it is ill-got. It will do the possessor most good who has earned it. To have it and not use it makes a miser. To misuse it makes a spendthrift. To use it well is the mark of a wise man.—Leon J. Richardson.

<sup>1</sup> Lockhart-Mummery: *Diseases of the Rectum and Colon*, L. Wood & Co., Baltimore, 1934.